



BSA Physicians Group, Inc.

MR # _____

Patient Name: _____

Patient Date of Birth: _____

ADMISSION RECORD and FINANCIAL AGREEMENT

The patient, or the responsible party signing for the patient, consents to all examinations, medical, surgical, and diagnostic procedures which may be deemed advisable or necessary by the patient's physicians serving on the Medical and Dental staff of BSA Health System (sometimes referred to as BSA). It is agreed that the patient should remain in BSA until the patient's physicians recommend discharge.

It is acknowledged and agreed that some of the PHYSICIANS involved in the patient's care and furnishing services to the patient are independent contractors and are not employees or agents of BSA Health System.

NOTICE OF PRIVACY PRACTICES

BSA is required by law to maintain the privacy of each patient's health information and to provide each patient with a description of the privacy practices. The patient or the responsible party signing for the patient acknowledges having had a copy of the BSA Notice of Privacy Practices made available to them.

ASSIGNMENT TO THE HEALTH SYSTEM

In consideration of services rendered or to be rendered, the patient, or the person signing for the patient ("representative"), hereby irrevocably assigns and transfers to BSA any benefits payable for the patient's benefit under hospitalization, sickness, health, liability or accident insurance, and any other insurance or other healthcare coverage including major medical, ERISA benefits, benefits of any health maintenance organization or participating provider organization or any reimbursement or prepaid healthcare plans, for the payment of services rendered. This irrevocable assignment includes insurance benefits from PIO, uninsured and underinsured motorist coverage. The patient/representative signing also irrevocably assigns to BSA an undivided interest in any legal, negligence, tort or other liability claims or other claims, including insurance and ERISA claims, the patient may have against any entity as a result of the condition for which treatment is sought or provided. These assignments authorize but do not obligate BSA to file or prosecute suits, insurance and ERISA claims or appeals. The patient/representative also irrevocably assigns to practitioners insurance and other healthcare benefits payable for services they provide during their stay. All payors described above are directed to pay directly to BSA all benefits due for hospital services and treatment rendered. Any amounts actually paid by benefit providers shall be applied to the patient's bill.

MEDICARE ASSIGNMENT and AUTHORIZATION

The patient, or the responsible party signing for the patient, certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. Further, authorization is granted to any holder of medical or other information to release to the Social Security Administration, Centers for Medicare and Medicaid Services (CMS), or their intermediaries or carrier, any information needed for this or any related Medicare claim. Authority is given that payment of authorized benefits be made on the patient's behalf.

AUTHORIZATION / PRECERTIFICATION

The patient, or the responsible party signing for the patient, acknowledges that the patient's group or private insurance policy may require prior certification, authorization, second opinions, or any other type of utilization review function. The patient, or the responsible party signing for the patient, understands the responsibility for compliance with these and all other terms of the patient's policy or group requirements. BSA's failure to obtain pre-authorization or pre-certification shall not relieve the patient or the responsible party from primary responsibility to pay the patient's incurred hospital bill and/or a BSA affiliated provider bill.

AUTHORIZATION TO APPEAL

The patient/representative hereby irrevocably authorizes but does not require BSA to appeal on the patient's behalf any claim(s) that delays or denies claim payment, and further authorizes any payor, including those listed to release any and all information requested and/or related to claim(s) to BSA and/or its attorneys. Any appeal brought by BSA shall be treated as brought by the patient personally.

PATIENT VALUABLES

All parties are advised that valuables should not be kept in their respective BSA room or treatment areas. Proper and safe facilities for any valuables are offered by BSA. BSA IS NOT RESPONSIBLE FOR VALUABLES NOT PROPERLY REGISTERED. BSA cannot be responsible for personal belongings and it is strongly urged that you not keep any personal items of significant value in your room or treatment areas.

TELEPHONE CONSUMER PROTECTION ACT

The patient, or the responsible party signing for the patient, authorizes our employees, assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you, and include in any such message information required by law (including debt collection laws) and/or regarding amounts owed by you; (3) to send you text messages or emails using any email addresses you provide; (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an "auto dialer") in connection with any communications made to you or related to your account.

PATIENT FINANCIAL RESPONSIBILITY

The patient, or the responsible party signing for the patient, agrees to pay to BSA its standard charges for hospitalization, examinations, medical, surgical, and diagnostic procedures, treatment, and supplies, which may be deemed advisable or necessary by the patient's physicians. All charges made to the patient's account shall be payable within 30 days of discharge from BSA, unless prior payment arrangements have been made.

In the event the patient is covered by Medicare, a preferred provider organization, health maintenance organization, health insurance policy or plan, workers compensation insurance, and/or other health benefits contract, which is accepted by BSA, and which limits the patient's liability for such charges, BSA shall bill in compliance with such contract.

If the patient is not contracted by such a contract, or if such a contract does not apply to the patient's admission, the full amount of the charges billed to the patient shall be payable by the patient, or the responsible party signing for the patient. The charges billed to the patient shall be payable without discount except for provided by BSA's Prompt Pay discount or Financial Aid/Uncompensated Charity Care Policies, or reference to other payment sources not available to the patient. BSA's election to pursue one or more forms of collection shall not constitute a waiver of its right to pursue other collection measures it deems advisable or necessary. All such remedies shall be cumulative in nature. Venue for collections shall be Potter County, Texas. This agreement shall not require payment by any person in contravention of any state or federal statute, rule or regulation.

Patient understands and agrees that any claim or civil action against BSA and/or an affiliated BSA and/or an affiliated BSA provider for medical treatment and/or other related services provided at BSA Hospital and/or a BSA affiliated provider shall be governed and enforced by the laws of the State of Texas. Patient further consents to Potter County, Texas for any proceeding as between BSA and patient that may be brought, or arise out of, in connection with, or by reason of patient's medical treatment at BSA Hospital and/or by BSA affiliated provider.

ELECTRONIC PRESCRIBING

Our facility participates in Electronic Prescribing and will be asking for your preferred pharmacy to submit any prescriptions necessary upon your discharge. To facilitate this process we will be submitting your phone number and address on file to your preferred pharmacy.

I have read the information above and/or had it explained to me and I understand and agree to it.

Responsible Party Name (Please Print)

Responsible Party Signature

Date

Relationship if patient does not sign

Co-Pays and Referrals

All copays are subject to allowed amounts by each insurance carrier. BSA Urgent Care may collect a higher copay as noted on insurance card presented at time of service. In the event of an overpayment you will receive a refund after all applicable balances have been settled.

Self pay patients are allowed a 25% discount on charges when paid in full. All charges are billable for services rendered. In the event that a charge is not billed on date of service, patients will receive a statement for these services and will still be eligible the 25% paid in full discount.

Please note that not all insurance plans allow this office to refer patients for diagnostic testing and/or additional treatment by specialists. If your insurance plan has such a restriction you will be responsible to obtain a referral for these recommended services by your primary care provider. BSA Urgent Care is not a primary care provider.

Signature X _____ Date _____



We would like to welcome you to our clinic and thank you for allowing us to be your healthcare provider. We would like to tell you some of the ways you can help us better serve you. Please let us know if we fail to meet ANY of your expectations.

1. Please bring all your medications with you when you come in the clinic. In this way we can coordinate our treatment plans with those of other healthcare providers. This would include immunization records, (unless you have received them in this clinic) if you are less than 21 years of age.
2. When you need refills on your prescription, please call before exhausting your supply. It is not always possible to make all communications between your doctor and your pharmacy on a same day basis. GIVE US AT LEAST 24 HOURS AND LONGER ON THE WEEKENDS.
3. If your prescription drugs include any form of narcotics, these cannot be filled without your physician reviewing your chart and calling your pharmacy. No other physician can refill narcotic drugs.
4. We know that sometimes when a patient becomes ill their physician is not available and another physician is covering for that doctor. This is common in a group practice. However, your Primary Physician will be notified and will take over your treatment as soon as possible.
5. If you are under the age of 18, you must be accompanied by a parent or guardian.

FINANCIAL POLICY

1. You are responsible for making sure our physicians and services are covered by your insurance plan. Please check with your insurance company prior to your first visit with us. We require payment at the time of service. Cash, check, Visa, Mastercard and American Express are accepted. Proof of insurance coverage will be required. Please bring your insurance card with you when you are seen.
2. WE RESERVE THE RIGHT TO DENY NON-EMERGENCY TREATMENT FOR ANY PATIENT WHO HAS AN OUTSTANDING BALANCE WITH ANY PROVIDER IN OUR NETWORK.
3. You will be charged for all services done in the office. You may also be charged from a pathologist and/or radiologist for reading and interpreting your lab work or x-rays.

PLEASE NOTIFY OUR OFFICE OF ANY INSURANCE, ADDRESS, OR TELEPHONE CHANGES.

We hope that this will help you understand our desire to serve your medical needs in the best possible manner. Thank you for choosing BSA URGENT CARE CENTER.

Signature of Patient or Guardian

BSA Urgent Care Center
4510 South Bell
Amarillo, Texas 79109
(806) 212-4835



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HIPAA INFORMATION RELEASE FORM

BSA Physicians Group, Inc. complies with HIPAA regulations; therefore we require that you complete the following section. Please understand that we can only share information with the person(s) and/or organization(s) that you list. Any person(s) and/or organization(s) that are not listed can only receive information after the patient or the patient's responsible party has signed a release of information form. The list below will be considered valid unless a written request is received by the patient or the responsible party revoking consent.

Name	Date of Birth	Phone Number	Will this person be bringing the patient to their appointments?
Address	Relationship	Work Number	
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I grant permission for BSA Physicians Group, Inc. and its authorized personnel to release information to the above listed person(s) and/or organization(s) about my appointments, bills, medical treatment, medical plan and any other information associated with my being a patient.

Signature of Responsible Party

Date

Responsible Party (Please Print)